Performance-Based Contracting in Family Care
Background and Project

❖ PAY FOR PERFORMANCE BACKGROUND

Pay for Performance (P4P) initiatives attempt to reimburse, or reward, providers for meeting specific quality standards. These initiatives provide higher funding for providers that perform well and lower funding for providers that perform poorly, in contrast to traditional fee-for-service contracting arrangements that reimburse providers for the number of service units provided. Pay for Performance represents a very important approach for increasing the focus of reimbursement on the delivery of quality care.

A relatively new idea, Performance-Based Contracting (which is another name for Pay for Performance) has been increasingly well received by health care purchasers. A 1999 National Academy for State Health Policy (NASHP) paper on the topic identified only three states at the time that had "notable experience in the application of financial performance incentives or disincentives" (IA, MA, and RI). By 2004, the topic was a major focus of the NASHP annual state health policy conference. Wisconsin began considering implementation of some sort of P4P program for its Medicaid managed care program in the late 1990s, although no major initiatives have been implemented.

Many large, private sector, health care purchasers are now employing performance based contracting across the country (e.g., GE, GM, WellPoint). However, perhaps the greatest supporter of these initiatives is CMS. CMS has P4P demonstrations active. CMS also allows states the option to include incentive payments in Medicaid capitation payments. The Capitated Contracts Rate Setting Checklist, a guide for actuaries and administrators to ensure allowable Medicaid capitation payments are developed, clearly describes how states may implement incentive payments. Briefly, CMS requires incentive payments be actuarially sound and based upon Medicaid approved services, and the amount of the payment cannot exceed 105% of the approved capitation payment.

Wisconsin Family Care has added P4P to its CY 2006 CMO capitation rates to improve the quality of health care provided to CMO members.

❖ PROJECT OVERVIEW

The current project would provide an incentive payment to CMOs who implement an effective diabetes management program in CY 2006. Diabetes is a major health issue that impacts roughly one-third of total Family Care membership (i.e., 3,530 of 11,132 persons in CY 2004). Historically, CMOs have not closely attended to this area. CMOs do not purchase the majority of primary and acute care provided to their members and have focused on managing the services they purchase, long-term care services. However, if CMOs use their in-house nurses to manage their members' diabetes, they can positively impact Medicaid and Medicare costs in both long-term and primary and acute care. Therefore, a diabetes management Pay for Performance initiative has been implemented to incentivize Family Care CMOs to focus on diabetes management.

The project will reward CMO performance in three areas:

> 1) Coordination of care efforts that result in ***achieving and documenting one or more hemoglobin A1-c tests (professionally evaluated blood glucose tests) per member per year for 75% of members with diabetes***,

2) Coordination of care efforts that result in ***reductions in the percentage of members with poorly controlled diabetes***, and
3) Coordination of care efforts that result in ***improvement in the rate of preventable hospitalizations and preventable ER visits***.

The Department will quantify CMO performance on the percentage of diabetic members with one or more A1-c tests and reductions in the percentage of members with poorly controlled diabetes using measures developed by the National Diabetes Quality Improvement Alliance and adopted by the National Committee on Quality Assurance for the Health Employer Data Information Set (HEDIS) measures. The State's external quality review organization (EQRO) will provide data validation.

The Department will also quantify a CMO's success in reducing preventable hospitalizations using a series of well-researched measures developed by the Agency for Healthcare Research and Quality (AHRQ). These are calculated using Medicaid claims data. For ER visits, the Department is using the AHRQ definitions for preventable hospitalizations for this measure and to quantify a CMO's impact in this area, also relying on claims data.

In the initial year of Pay for Performance, to receive an incentive payment for A1-c testing, CMOs will have to meet the 75% target. For improvements in members' poorly controlled diabetes, preventable hospitalizations and ER visits, CMOs will be measured against their own baseline and not against each other. The incentive payments in these areas will also be graduated, so that the greater the impact a CMO had on its quality measures, the larger the incentive payment it can receive.

In total, initial incentive payments will not exceed $1,008,500 AF if each CMO realizes its highest target levels. Payments will be made based on a CMO's impact on the measures in CY 2006. CMOs will be reimbursed in early-to-mid 2007 (SFY 07) through a retrospective rate adjustment. Retrospective adjustments are already done annually for the CMOs.

Family Care Medicaid Funding (Numerics 406 and 456) is the funding source for the incentive payments. Although it is expected that better diabetes management will result in primary and acute care cost savings, costs analyses show insufficient Medicaid fee-for-service savings to fully finance an incentive payment. This is because Medicare is the principal payer of acute care for Family Care members. A projection of Family Care Medicaid costs in the 2005-2007 Biennium shows sufficient funds for an incentive payment.

❖ PROJECT GOALS

The objective of this specific proposal is to better align two key Family Care program goals. These are (1) ***improving the overall quality of the long-term care system*** by focusing on achieving people's health and social outcomes; and (2) ***enhancing the cost-effectiveness of the State's long-term care system*** for the future. The Department seeks to achieve these goals by incentivizing the CMOs to:

- reduce the complications associated with diabetes;
- improve the quality of life of persons living with diabetes; and
- reduce the overall costs associated with treating the complications of diabetes.

❖ RATIONALE/MOTIVATION

It is important that any P4P project be ***both clinically significant and also achieve cost savings***. In other words, any improvements in care that are being incentivized should not be more costly (e.g., new technologies). The two perspectives of quality and cost savings must be perfectly aligned. A traditional health care case that is used is caesarean sections, which are both more costly and generally used as a measure of lower quality. An incentive program that reduces these therefore generates savings *and* increases the quality of care delivered. Finding an analogous topic in the delivery of long-term care services is somewhat more challenging.

The ***clinical rationale*** for focusing on diabetes in an incentive program is very clear. First, the clinical pathway for diabetes is well-known, particularly if the disease is not well-managed. Diabetes is a disease in which the body has difficulty using or producing insulin, which is critical in the body's process for converting sugars and other foods into usable sources of energy. The American Diabetes Association (ADA) estimates that there are 18.2 million people in the United States who have diabetes; this represents about 6.3% of the population. While the root causes of diabetes are not know, strategies for managing the disease are well-known. They typically involve the proper management of the disease by the patient, and they also traditionally involve a team that includes a wide range of health care professionals.

The basic approaches of an effective diabetes management program include close attention to diet, a regular exercise regime, weight loss, and possibly medication. Routine blood testing is a key component of an effective program. The ADA calls blood testing "one of the best tools for keeping diabetes in control. Frequent testing and good record-keeping give…the most accurate possible picture of [one's] diabetes control." This is because blood glucose levels must be maintained with an individual-specific range of values. Failure to do this basic maintenance and control leads to either hypo- or hyperglycemia in the short-run. Complications in the longer-run include heart disease, stroke, kidney disease, glaucoma, cataracts, retinopathy, and nerve damage (or neuropathy). Many of these complications, however, are completely avoidable with good preventative care. Thus, the real impact that a well-developed and well-coordinated care plan can have on an individual's health is quite significant.

The ***fiscal rationale*** for focusing on diabetes is also compelling. The following table shows the Medicaid primary and acute care cost for persons with diabetes who were enrolled in Family Care over the past five years (Groups 2 and 3), relative to persons with no diabetes (Group 1) who were enrolled in the program. The cohort with diabetes is further split into two sub-groups, demonstrating a significant cost difference between the group of persons with preventable hospitalizations (Group 3) and those without such admissions (Group 2).

Medicaid Primary & Acute Care PMPM, Family Care Enrollees,
By Year, Diabetes Status, and Diabetes-Related Hospital Admission Status

	Year				
Cohort	**2000**	**2001**	**2002**	**2003**	**2004**
1. Persons without Diabetes	$ 303.19	$ 322.14	$ 383.78	$ 418.57	$ 435.90
2. Persons with Diabetes but No Hospital Admits	$ 525.64	$ 536.78	$ 573.42	$ 619.96	$ 665.29

Relativity: Group 2 / Group 1	1.73	1.67	1.49	1.48	1.53
3. Persons with Diabetes and Hospital Admits	$ 926.85	$ 679.15	$ 911.39	$ 1,550.60	$ 1,036.65
Relativity: Group 3 / Group 2	1.76	1.27	1.59	2.50	1.56
4. All Enrollees (Groups 1, 2, and 3 above)	$ 356.10	$ 378.11	$ 442.47	$ 491.14	$ 514.48

Data Source: Wisconsin Medicaid Management Information System data, as analyzed by DDES staff.

The cost difference between Groups 2 and 3 above is one way to conceptualize the potential savings from a successful P4P program in the area of diabetes management. In other words, a somewhat crude way of thinking about the program is that the goal is to "move" enrollees from Group 3 into Group 2. And, all else equal, if the CMOs are able to successfully move a person, the savings would be on the order of $370 PMPM (relying on the highlighted CY 2004 cells above).

A more realistic approach to the potential savings is to isolate the service areas that might actually be impacted by "moving" persons from Group 3 to Group 2. For example, the table below shows that not all of the savings conceptualized above would be realized from the reductions in hospitalizations per se. While not insignificant, only about $225 PMPM of the $370 difference cited above would be realized from hospital savings (see shaded cells for CY 2004, below).

Medicaid Primary & Acute Care PMPM by Service, Family Care Enrollees,
By Year, Diabetes Status, and Diabetes-Related Hospital Admission Status

	Year				
Services for Cohort 2	**2000**	**2001**	**2002**	**2003**	**2004**
DRUGS	$ 323	$ 330	$ 350	$ 397	$ 425
INPATIENT HOSPITAL	$ 87	$ 83	$ 99	$ 101	$ 97
PHYSICIAN AND PHYSICIAN CLINIC	$ 23	$ 26	$ 31	$ 31	$ 38
OUTPATIENT HOSPITAL	$ 60	$ 57	$ 51	$ 54	$ 69
ALL OTHER	$ 33	$ 41	$ 41	$ 38	$ 36
TOTAL	$ 526	$ 537	$ 573	$ 620	$ 665
	Year				
Services for Cohort 3	**2000**	**2001**	**2002**	**2003**	**2004**
DRUGS	$ 485	$ 317	$ 407	$ 495	$ 499
INPATIENT HOSPITAL	$ 216	$ 205	$ 262	$ 562	$ 323
PHYSICIAN AND PHYSICIAN CLINIC	$ 45	$ 34	$ 63	$ 116	$ 80
OUTPATIENT HOSPITAL	$ 75	$ 54	$ 111	$ 291	$ 62
ALL OTHER	$ 105	$ 69	$ 69	$ 87	$ 74
TOTAL	$ 927	$ 679	$ 911	$ 1,551	$ 1,037

Data Source: Wisconsin Medicaid Management Information System data, as analyzed by DDES staff.

❖ THE MEASURES

Again, the Family Care CMOs will be measured in three areas:

1) Achieving and documenting ***one or more hemoglobin A1-c tests in a year for 75% of members with diabetes***,

2) The percentage of ***members with poorly controlled diabetes***, and

3) The rate of ***preventable hospitalizations and preventable ER visits***.

These measures will be used to monitor each CMO's performance on managing their members' diabetes.

The A1-c indicator, as well as the other three outcomes measures being used to monitor CMOs' performance on reducing the percentage of members with poor diabetes control, were developed by the National Diabetes Quality Improvement Alliance. They have been adopted by the National Committee on Quality Assurance for the Health Employer Data Information Set (HEDIS) measures. They are as follows:

Indicator Name	**Description**
A1c Management – Testing Rate	Numerator: Diabetes patients with one or more A1c tests in a year Denominator: All adult patients diagnosed with diabetes
A1c Management – Poor Control Rate	Numerator: Diabetes patients with most recent A1c level > 9% Denominator: All adult patients diagnosed with diabetes
Lipid Management – Poor Control Rate (LDL – Cholesterol)	Numerator: Diabetes patients with most recent LDL-C > 100 Denominator: All adult patients diagnosed with diabetes
Blood Pressure Management – Poor Control Rate	Numerator: Diabetes patients with most recent blood pressure > 140/90 mm Hg Denominator: All adult patients diagnosed with diabetes

Complications correlated with the above measures are microvascular complications, coronary heart disease, heart failure and strokes. Members with poorly controlled diabetes, as defined by these measures, are at greater risk for these complications.

The key outcomes measures that used to monitor CMOs' performance on preventable hospitalizations were developed by the Agency for Healthcare Research and Quality (AHRQ). Formerly known as the ambulatory care sensitive conditions (and now called the Prevention Quality Indicators, or PQIs), they were developed on the premise that active prevention activities that occur in the community will reduce or eliminate the need for such hospitalizations. They are as follows:

Indicator Name	**Description**
Diabetes Short-term Complication Admission Rate	Number of admissions for diabetes short-term complications per 1,000 diabetics.
Diabetes Long-term Complication Admission Rate	Number of admissions for long-term diabetes per 1,000 diabetics.

Uncontrolled Diabetes Admission Rate	Number of admissions for uncontrolled diabetes per 1,000 diabetics.
Rate of Lower-extremity Amputation Among Patients with Diabetes	Number of admissions for lower-extremity amputation among patients with diabetes per 1,000 diabetics.

For ER visits that do not result in hospital admits, the Department created a measure using the Short-term Complication, Long-term Complications, and Uncontrolled Diabetes procedure codes. In other words, the same logic that underpins the preventable hospitalization measures has been applied to ER visits. The exception is when the ER visits *turn into* hospital admits (and thus are already being counted).

Please see Appendix A for more detail on how these indicators will be measured for CMOs.

❖ **MEASUREMENT: BASELINE**

A baseline calculation is required to measure reductions in members with poorly controlled diabetes and in preventable hospitalizations and ER visits. To calculate a baseline, the measures are combined within each of the two major categories: 1) preventable hospitalizations and ER visits, and 2) members with poor diabetes control. That is, the individual measures listed above will not be monitored themselves, but they will be composited within these two broad domains, largely to avoid problems associated with small numbers. Two targets are therefore be set for each CMO.

For example, for members with poorly controlled diabetes, the baseline measure is calculated as an average percentage of individuals with poorly controlled diabetes across the three indicators: A1c, LDL-C and blood pressure.

For preventable hospitalizations and ER visits, the five rates are added together to become a combined measure. The five individual measures are essentially summative into one indexed number per CMO.

The baseline period for measurement of preventable hospitalizations and ER visits, by CMO, has already occurred. The Department's former actuarial firm suggested that it would be best to update these data with the most recent and available information, when it was time to establish the baseline for insertion into the CMO contract. Thus the baseline period chosen was July, 2002, though June, 2005.

The baseline rates for preventable hospitalizations and ER visits for persons with diabetes in the FC CMOs are shown in the table below. Note that these are standardized, disease-specific rates (i.e., the numbers represent number of ***preventable hospital admissions and ER visits per 1000 diabetics*** using the procedure codes defined by the AHRQ), and have been weighted to the count third year's rate more heavily than the first and second years' rates.

CMO County	SFY 2003 Rate	SFY 2004 Rate	SFY 2005 Rate	3-Year Average	Weighted Average
Fond du Lac	39.0	22.4	33.1	30.7	31.5
La Crosse	45.5	29.6	14.9	37.5	20.9
Milwaukee	54.1	43.3	32.3	48.7	36.7
Portage	82.8	54.1	72.5	68.4	69.8
Richland	87.0	53.2	88.2	70.1	81.1

Data Source: Wisconsin Medicaid Management Information System data, as analyzed by DDES staff.

SFY 2005 comprises 70% of baseline; SFY 2004 comprises 20% of baseline, and, SFY 2003, 10% of baseline. This weighting is to account for improvements in hospitalizations and ER visits in more recent years for CMOs who implemented diabetes management prior to Pay for Performance.

Baseline measurement of members with poor diabetes control, by CMO, will be collected by April 1, 2006, by DHFS and verified by the EQRO (MetaStar). Baseline data for this measure is not included in the CMO contract. However, because each CMO's improvement is measured against its own baseline, not including baseline data in the contract for this measure should not hinder CMOs' diabetes management efforts.

❖ **MEASUREMENT: POST IMPLEMENTATION**

For the preventable hospitalization and ER visit measures, the Department will provide feedback to CMOs on their measures during the course of the contract period. Final measurement will occur once claims data are finalized for CY 2006.

Below are the target levels the CMO would need to realize the incentive payment.

CMO County	Target Rate - 10% Reduction from Base	Target Rate - 20% Reduction from Base	Target Rate - 30% Reduction from Base	Target Rate - 40% Reduction from Base
Fond du Lac	28.4	25.2	22.1	18.9
La Crosse	18.8	16.7	14.6	12.5
Milwaukee	33.0	29.3	25.7	22.0
Portage	62.8	55.8	48.9	41.9
Richland	73.0	64.9	56.8	48.7

For the A1-c testing measure and the members with poorly controlled diabetes measures, CMOs will track their own progress using their own electronic database of clinical tests such as a diabetes registry that MetaStar can assist them in setting up. CMOs are required to submit final measurements from their electronic database by December 31, 2006. Metastar will verify this data.

❖ **INCENTIVE STRUCTURE**

There will be separate incentive payments for the (1) A1-c testing rate, (2) preventable hospitalizations and ER visits, and (3) proportion of members with poorly controlled diabetes. The latter two payments will be graduated, so that the greater the impact a CMO had on its

quality measures, the larger the incentive payment it would receive. Graduated payments are a fundamental feature of all successful P4P initiatives.

The incentive payment for A1-c testing, in contrast, will not be graduated. To receive the incentive payment for A1-c testing, CMOs must document in members' case files and in their electronic diabetes database that one or more A1-c tests were performed per member per year for 75% or more of their members with diabetes. Data from the National Committee for Quality Assurance shows that health care providers, after implementing a diabetes management program, were able improve the rate of A1-c testing in their Medicaid population from 69% to 75%. It is believed that closely monitoring CMO progress on this process will result in improvement in the other outcome areas discussed above.

With respect to the preventable hospitalizations and ER visits, four graduated incentive levels will be achievable by a CMO:

1. 25% of the incentive (i.e., 25% of the portion available for this incentive payment) will be awarded for a 10% reduction in these rates;
2. 50% of the incentive will be awarded for a 20% reduction in these rates;
3. 75% of the incentive will be awarded for a 30% reduction in these rates; and
4. 100% of the incentive will be awarded for a 40% reduction in these rates.

With respect to percent of members with poorly controlled diabetes, two incentive levels will be achievable by a CMO:

1. 50% of the incentive (i.e., 50% of the portion available for this incentive payment) will be awarded for a 3% reduction in the rates; and
2. 100% of the incentive will be awarded for a 6% reduction in these rates.

Data from the National Committee for Quality Assurance indicates that a 6% reduction in the percentage of patients with poorly controlled diabetes is the greatest impact affected by health care providers implementing diabetes management programs.

The incentive payments are not equally split across the three categories. The Department is providing a larger reward for achieving a 75% A1-c testing rate. This is an area the Department is emphasizing in this first year.

Of the over $1,000,000 in funding available for incentive payments to all CMOs, approximately 50% ($500,000) will be made available to CMOs achieving the A1-c testing rate, approximately 25% ($250,000) will be made available to CMOs improving the proportion of members with poorly controlled diabetes, and approximately 25% ($250,000) will be made available to CMOs for improving the rate of preventable hospitalizations and ER visits.

Maximum achievable incentive payments available to each CMO have been developed considering fixed costs for implementing a diabetes management program regardless of the number of diabetics enrolled in a CMO and variable costs due to differences in the number of diabetics in each CMO. The maximum incentive payments by CMO in each measurement area are:

CMO	HgA1-c Testing Rate = 75%	Improvement of Percent Members with Poorly Controlled Diabetes	Improvement in the Rate of Preventable Admissions
Fond du Lac	$55,200	$27,600	$27,600
La Crosse	$73,700	$36,900	$36,900
Milwaukee	$278,900	$139,500	$139,500
Portage	$54,500	$27,300	$27,300
Richland	$41,800	$20,900	$20,900
Total	$504,100	$252,200	$252,200

❖ **FUNDING**

Experts in the field (e.g., the State's former and current actuarial firms) believe this project's incentive payments to be a very small. Both Milliman USA and PricewaterhouseCoopers (the Department's former and current actuarial firms) believe something in the range of 2% - 5% of capitation to be a reasonable incentive target level. In the case of Family Care, incentive levels of that proportion would represent roughly $4 - $6 million AF. It is important to note the rationale for using a larger incentive: it is generally thought that it will not capture a provider's attention and energy if it is too small, nor will it overcome critical start-up costs. However, Family Care CMOs are engaged in the Pay for Performance proposal with the understanding that the funding level will be low at the outset. It is also thought that, even at the initial low level, CMOs start up costs would be covered if they perform well. It is envisioned that this program will grow in future years to reach the industry norm.

Funding currently allocated to the Family Care budget will be used to fund the proposal. A projection using most recent enrollment figures and CY 06 capitation rates shows sufficient funding to cover the incentive payments.

❖ **IMPLEMENTATION ISSUES**

The key implementation strategy is to begin a small P4P program in CY 2006, with an eye toward expanding in CY 2007 and beyond. To this end, the initial program is an "upside-only" incentive for the CMOs. This will allow a CMO to realize a modest financial gain in 2006, while not subjecting them to any risk, or any additional cost, if they do not perform well. Yet, this approach would also likely cover most, if not all, of a CMO's start up costs of its diabetes management program if they perform strongly. In a more traditional P4P program, there may be some providers that would realize their incentive payment and others that would lose funding as a result of not achieving their targets. This symmetrical incentive structure introduces some offsetting revenues, so that the "losers" are financing some of the "winners" financial gains.

While CY 2006 will present an upside-only incentive for the CMOs, the Department's intent is to move toward a more symmetrical structure for CY 2007. In other words, there would be an opportunity for the CMOs to have to "earn" part of their capitation, and failing to meet certain quality targets would mean they would have to make payments back to the State. The CMOs

have been informed of this intent, though no details associated with a symmetrical incentive structure have been discussed to date.

❖ COMMUNITY PARTNERS

The CMOs have been encouraged to create local partnerships with other organizations in their communities that may already be focusing on diabetes management. Also, as a practical matter, MetaStar has stated that CMOs must develop cooperative relationships with their diabetic members' primary and acute care providers to implement a program to reduce the percentage of CMO members with poorly controlled diabetes. Local partnerships between the CMOs and primary and acute providers may result in the development of comprehensive local disease management programming.

For example, the CMO in Milwaukee County has identified the Medical College of Wisconsin as having a shared focus on diabetes management. They have also discussed reaching out to the Wisconsin Partnership Program site in Milwaukee County to assist their effort. The CMO in Richland County has been encouraged to reach out to the local hospital, with whom they have historically had an excellent working relationship. La Crosse County has been working on a Business Case for Quality grant from the Center for Health Care Strategies (CHCS) that has a focus on diabetes management and attempts to quantify the costs and savings associated with a targeted intervention. This project has already included strong outreach to hospitals and clinics in the La Crosse area.

It has been recognized by the CMOs that an issue such as diabetes management is a system-wide health care issue. The CMOs cannot themselves necessarily impact the whole system but represent another key player adopting new technologies. The Department's role, as a major purchaser of both health and long-term care services, could be to encourage the development of these innovative, cross-cutting alliances.

❖ TECHNICAL ASSISTANCE (I.E., THE DHFS ROLE)

DHFS has provided leadership in moving Pay for Performance to the forefront of policy discussions with the Family Care CMO Directors. The Department has provided background information, organized a briefing by representatives from The Alliance, identified appropriate measures, calculated initial hospitalization rates for each of the CMOs, and developed a small steering committee to oversee and guide the work. The CMOs have also been independently working with MetaStar to develop the local programming that would help them achieve the incentive payment.

As the program begins, DHFS has provided information to the CMOs to facilitate their improved diabetes care management. For example, DHFS has provided each CMO a list of their members with diabetes and those with hospitalizations and ER visits to assist with the initial development of their diabetes registries. Standardized reports out of the data warehouse are planned to provide important, timely information to the CMOs.

❖ CONTRACT LANGUAGE

The CY 2006 Family Care contract includes detailed information on the Diabetes Management Pay for Performance project under Section V. Actuarila Basis, C. Retrospective Adjustments.

Appendix A

Measuring CMO Performance

Specifically, each CMO's performance will be measured as follows:

I. Achieving and documenting one or more hemoglobin A1-c tests in a year for 75% of members with diabetes:

a) If CMOs choose to participate in the Pay for Performance Initiative, at the end of CY 2006, each CMO will be required to run a December 31, 2006 report from its electronic database of clinical data for members with diabetes showing: 1) the number of diabetic members with one or more A1c tests within the last 13 months from the report date, and 2) the number of members who are diagnosed with diabetes.

- To be eligible for a Pay for Performance incentive payment, CMOs are required to maintain an electronic data system that includes their diabetic members' clinical tests, test dates and values.

- For this portion of the Pay for Perfomance incentive, a CMO's data system must include all diabetic members' A1-C tests, test dates and values for tests completed between December 1, 2005 and December 31, 2006 and must be able to generate a report of members with diabetes, by Medicaid ID, and their A1-c tests, dates and values through December 31, 2006 as of January 31, 2007.

- The number of members with diabetes generated from CMOs' electronic systems on December 31, 2006 will be verified by DHFS.

- DHFS will verify CMOs' diabetic member lists by comparing them to a list of diabetics identified using MMIS claims data or the LTCFS. If a CMO member has a diagnosis of diabetes in either data system and has been a Family Care member for 3 or more months, DHFS will count this individual as a CMO member with diabetes. DHFS will use screen and claims data in the MEDS data system by January 10, 2007. By this date, the MEDS data system includes screens completed through early December, 2006 and claims for dates of service through November 2006.

- To identify potential discrepancies between the CMO's and DHFS' list of diabetics before January 2007, DHFS will provide its list to CMOs monthly.

- CMOs may request changes to DHFS' list of diabetics with justification.

- The number of members' A1-c tests reported by CMOs on 12/31/06 will be validated by Metastar in February 2007. Validation will compare a sample of records from the CMO database to CMOs' member records. Data must be validated by Metastar prior to it's consideration by DHFS for a CMO incentive payment.

b) The number of diabetic members with one or more A1c tests within the last 13 months from the report date will be used as the numerator and the total number of members with diabetes as the denominator in calculating the percentage of diabetic members with one or more A1c tests in a year.

c) CMOs who achieve a 75% or more percentage will receive an incentive payment under this measure.

II. The percentage of members with poorly controlled diabetes:

a) CMOs will be measured on their improvement in CY 2006 in the percent of members with poorly controlled diabetes. CMOs will report a baseline measurement from CMOs' electronic databases by April 1, 2006. This baseline report will be compared to a final report run by CMOs from their electronic databases on December 31, 2006.

- If CMOs have completed baseline data prior to April 1, 2006, they may opt to report baseline data earlier. Completed baseline data means that a CMOs electronic database includes test dates and values for the most recent A1-C, LDL-C, and blood pressure tests performed on all CMO members with diabetes - each member has a test, test date and value for each of the tests (A1-C, LDL-C and blood pressure).

- A CMO may not have completed baseline data by April 1, 2006. If this happens, a CMO may choose to not participate in this portion of the Pay for Performance initiative, or the CMO may report incomplete data to use as baseline. CMOs submitting incomplete data will be required to submit baseline data by April 1, 2006.

- Metastar will validate complete or incomplete baseline data submitted April 1, 2006 and validate final data submitted December 31, 2006 under this portion of the Pay for Performance incentive. Validation will compare a sample of records from the CMO database to CMOs' member records. Data must be validated by Metastar prior to it's consideration by DHFS for a CMO incentive payment.

b) CMOs that reduce the percentage of members with poorly controlled diabetes by 3, 4 or 5 percentage points will receive 50% of the incentive available under this portion of the Pay for Performance incentive. CMOs that reduce the percentage of members with poorly controlled diabetes by 6 percentage points or more will receive 100% of the incentive available under this portion of the Pay for Performance incentive.

c) Improvement in the percent of members with poorly controlled diabetes will be calculated as a reduction in the combined average rate of members' A1-c tests with a value greater than or equal to 9%, LDL-C with a value greater than or equal to 100, and blood pressure with a systolic value greater than or equal to 140 or a diastolic value greater than or equal to 90. This is a 'rolling' measure, i.e. CMOs average improvement

will account for changes in the number of diabetics between the baseline measure and final measure.

- Please consider the following example to understand how improvement in the percentage of members with poorly controlled diabetes will be calculated:

  CMO A submits baseline data by April 1, 2006 (this example should apply to a CMO that submits complete or incomplete baseline data by April 1)

  - At **baseline** 100 members in CMO A are identified as having diabetes.

    50 have A1-c tests
    60 have LDL-C tests, and
    80 have blood pressure tests
    25 have an A1-c value ≥ 9%
    30 have LDL-C ≥ 100, and
    35 have a systolic blood pressure value ≥ 140 **or** a diastolic value ≥ 90.

  - The CMO's **baseline** percentage of members in poor control will be calculated as follows:

    (25/50 + 30/60 + 35/80) / 3
    = (.5 +.5 + .44)/3
    = 48% of members in poor control

  - On **December 31, 2006**, CMO A now has 110 members identified as having diabetes

    85 have A1-c tests
    90 have LDL-C tests, and
    100 have blood pressure tests
    25 have an A1-c value ≥ 9%
    45 have LDL-C ≥ 100, and
    45 have a systolic blood pressure value ≥ 140 **or** a diastolic value ≥ 90.

  - The CMOs **final** percentage of members in poor control will be calculated as follows:

    (25/85 + 45/90 + 45/100) / 3
    = (.29 +.5 + .45)/3
    = 41% of members in poor control

  - The CMO's improvement in members with poorly controlled diabetes is the difference between 48% and 41%. This difference is 7%,

- CMO A gets the maximum incentive under this portion of Pay for Performance since their improvement is greater than 6%.

III. The rate of preventable hospitalizations and ER visits.

a) CMOs will be measured on their improvement (reduction) in CY 2006 in the rate of members with preventable diabetes related hospitalizations and ER visits. These measures, developed by AHRQ, are:

Indicator Name	Description
Diabetes Short-term Complication Admission Rate	Number of admissions for diabetes short-term complications per 1,000 diabetics.
Diabetes Long-term Complication Admission Rate	Number of admissions for long-term diabetes per 1,000 diabetics.
Uncontrolled Diabetes Admission Rate	Number of admissions for uncontrolled diabetes per 1,000 diabetics.
Rate of Lower-extremity Amputation Among Patients with Diabetes	Number of admissions for lower-extremity amputation among patients with diabetes per 1,000 diabetics.

For ER visits that do not result in hospital admits, the Department is using the Short-term Complication, Long-term Complications, and Uncontrolled Diabetes procedure codes applied to ER visits.

b) The Department (Department of Health and Family Services Bureau of Long-Term Support) has provided a baseline measurement, the weighted average, for each CMO below.

CMO County	SFY 2003 Rate	SFY 2004 Rate	SFY 2005 Rate	3-Year Average	Weighted Average
Fond du Lac	39.0	22.4	33.1	30.7	31.5
La Crosse	45.5	29.6	14.9	37.5	20.9
Milwaukee	54.1	43.3	32.3	48.7	36.7
Portage	82.8	54.1	72.5	68.4	69.8
Richland	87.0	53.2	88.2	70.1	81.1

The weighted average baseline weighs the third year's rate more heavily than the first and second years' rates. SFY 2005 comprises 70% of baseline; SFY 2004 comprises 20% of baseline, and, SFY 2003, 10% of baseline. This weighting is to account for improvements in hospitalizations and ER visits in more recent years for CMOs who implemented diabetes management prior to Pay for Performance.

c) As the total diabetic population for the hospital measures, a list of Family Care members with diabetes generated by DHFS is used. As in section a. i., DHFS will identify diabetics by CMO using MMIS claims data and the LTCFS. If a CMO member has a diagnosis of diabetes in either data system and has been a Family Care member for 3 or more months,

DHFS will count this individual as a CMO member with diabetes. DHFS will use screen and claims data in the MEDS data system by January 10, 2007 to determine the final study population. By this date, the MEDS data system includes screens completed through early December, 2006 and claims for dates of service through November 2006.

d) CMOs will receive DHFS' list of diabetics monthly under section a. i. and may request changes to DHFS' list of diabetics with justification.

e) The hospital measures are **'rolling'** measures. Hospital and total diabetic population data included in the above baseline data will be compared to a final report using a total diabetic population from the MEDS data system on January 10, 2007 and Medicaid hospital claims in the MEDS data system through April 10, 2007.The hospital and total diabetic population data in the final report will account for changes in membership.

f) The hospital data will include dates of service through December 31, 2006 and will be run in April to allow CY 2006 Medicaid claims run out.

g) To allow CMOs to monitor their hospital measures throughout 2006, DHFS will generate four CMO specific reports prior to the final report that show the baseline data updated on May 10, July 10, and Oct10 2006, and January 10, 2007.

h) CMOs who reduce the rate of members with preventable diabetes related hospitalizations and ER visits by 10% will receive 25% of the incentive available under this portion of the Pay for Performance incentive. In addition, a reduction of the rate by 20% will earn 50% of the incentive; a reduction of the rate by 30% will earn 75% of the incentive, and a reduction of the rate by 40% will earn 100% of the incentive.

i) Target hospital admission and ER visit rates for each level of incentive payment are shown below.

CMO County	Target Rate - 10% Reduction from Base	Target Rate - 20% Reduction from Base	Target Rate - 30% Reduction from Base	Target Rate - 40% Reduction from Base
Fond du Lac	28.4	25.2	22.1	18.9
La Crosse	18.8	16.7	14.6	12.5
Milwaukee	33.0	29.3	25.7	22.0
Portage	62.8	55.8	48.9	41.9
Richland	73.0	64.9	56.8	48.7

j) Reduction in the rate of members with preventable diabetes related hospitalizations and ER visits will be calculated as a reduction in the five rates added together. The calculation will account for changes in the number of diabetics between the baseline measure and final measure.

- Please consider the following example to understand how improvement in the rate of members with preventable hospitalizations and ER visits will be calculated:

  - For the **baseline** three years of data will be used: July 2002 through June 2005.

  - In CMO A, in each year, 100, 110, and 120 members, respectively, are identified as having diabetes. In each year, these individuals have had 5, 7, and 8 hospital admissions and ER visits, respectively, in total per year.

  - The CMO's **baseline** rate of hospitalizations and ER visits will be calculated as follows:

    (5/100 + 7/110 + 8/120) / 3
    = (.0500 +.0636 + .0667)/3
    = .0601
    As a rate per 1,000 diabetics = 60.1

  - On **January 10, 2006**, CMO A now has 125 members identified as having diabetes

  - On **April 10, 2007**, these 125 members identified on January 10, 2006 have had 5 hospitalizations and ER visits in total during CY 2006.

  - The CMOs **final** rate of hospitalizations and ER visits will be calculated as follows:

    5 / 125
    = 0.0400
    As a rate per 1,000 diabetics = 40.0

  - The CMO's improvement in members with poorly controlled diabetes is the percentage change from 60.1 and 40.0 calculated as: (40.0 - 60.1) / 60.1. This percentage change is -33%. [Note: a negative percentage means improvement].

  - CMO A gets 75% of the maximum incentive under this portion of Pay for Performance since their improvement is greater than 30% but less than 40%.